

informed consent sometimes differ,<sup>2,3</sup> causing yet another unacceptable double standard in distinguishing the two.<sup>12</sup>

Thirdly, public consultation is needed to determine the ideal balance between, on the one hand, individual confidentiality and data protection and, on the other, the legitimate use of patient-identifiable data without consent. Patients may not regard their contact with the National Health Service as constituting implied consent to the use of identifiable data about themselves for purposes other than their own medical care. However, there is a public interest in conducting observational research into diseases where little information is available and into audit of medical services which might be inadequate.<sup>2</sup> Hindering this process may be unethical.<sup>13</sup>

Ambiguous statutory regulations, contradictory guidance, and a vocal minority of objecting patients or those representing them will thwart observational research relying on patient-identifiable data, audit, and clinical governance. Investigators must design studies appropriately and need to know that their use of existing, valuable datasets is legitimate. Ethics committees must review proposals consistently and should not be threatened with court action to determine where the public interest lies. Patients should be made aware of which data about them may be used for purposes which further the public interest and the understanding and management of their own disorder.<sup>10</sup>

We are in a period of transition. In addition to the Human Rights Act 1998, which incorporates most of the European convention on human rights, there may be further implications if Britain signs and ratifies the European Convention on Human Rights and Biomedicine<sup>14</sup> and a protocol in preparation which may cover observational research. This is an important time

to protect the legitimate use of patient-identifiable data for unbiased observational medical research and audit.

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Competing interests: RAS and CPW have been and are still doing observational research and audit.

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## The current status of psychological debriefing

*It may do more harm than good*

Despite the widespread use of psychological debriefing, serious concerns have been raised about its effectiveness and potential to do harm.<sup>1,2</sup> Psychological debriefing is broadly defined as a set of procedures including counselling and the giving of information aimed at preventing psychological morbidity and aiding recovery after a traumatic event. In 1995 Raphael and colleagues emphasised that there was an urgent need for reliable evidence from randomised controlled trials on the impact and worth of debriefing.<sup>3</sup> Unfortunately, the news has not been good for debriefing.

Debriefing is generally applied within the first few days after a traumatic event, lasts one to three hours, and usually includes procedures that encourage and normalise emotional expression. Debriefing can also be more narrowly defined in terms of the procedures used, the information provided and the target population. One example of this type of debriefing is known as critical incident stress debriefing.<sup>4</sup>

A recent Cochrane review of eight randomised trials found no evidence that debriefing had any impact on psychological morbidity.<sup>5</sup> The authors recommended that compulsory debriefing should cease. This was in part based on evidence that poorer outcomes were sometimes associated with debriefing. In this week's *BMJ*, the large randomised trial of debriefing after childbirth by Small et al (p 1043) provides yet more evidence that debriefing is ineffective.<sup>6</sup> This study also provides further evidence that negative outcomes may be associated with debriefing.

Evidence about the ineffectiveness of debriefing has come from randomised trials that have used broad definitions of debriefing; thus, it might be that these findings have arisen because an inappropriate form of debriefing was used. It has been argued that if a more prescribed form, such as critical incident stress debriefing or its descendant, critical incident stress management, were used the outcomes would be different. However, there have been no published, randomised

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controlled trials using these prescribed approaches. There has also been no randomised controlled trial comparing the different types of debriefing. Therefore, until there is evidence there is no support for using one type of debriefing over any other.

Debriefing is a "grassroots" intervention that is popular among many health and allied practitioners. Some of them are likely to continue to advocate its use in spite of the lack of empirical support for it. Organisations such as banks and hospitals are likely to continue using it since there is no comparable broadly acceptable early intervention that is comparatively low cost. The continued use of debriefing might not matter (other than to taxpayers and shareholders) if studies had found that psychological debriefing had no effect or a positive effect on recovery. But this is may not be the case. Distress after trauma typically reduces over time, stabilising at levels that are proportional to the initial traumatic event.<sup>7</sup> For debriefing to be worthwhile it should at least accelerate the downward trajectory of distress. What should concern practitioners, organisations, and researchers is that not only does the evidence indicate that this is not happening, but it also indicates that debriefing may prolong the process of recovery.

Why should this happen? Research shows that certain factors probably have an impact on the recovery process, such as the perception that a trauma was life threatening, the person's premorbid psychiatric state, and the presence of serious ongoing stressors.<sup>7, 8</sup> Other factors may also affect recovery—for example, people's expectations of their responses and reactions. Thus, it has been suggested that debriefing "medicalises" normal distress by generating in an individual the expectation of a pathological response.<sup>5</sup> Personality and coping style may also interact with debriefing and affect recovery. However, this relation is likely to be complex. For example, a tendency to avoid rather than

confront emotionally distressing experiences is associated with poorer outcomes after trauma, suggesting that people with this tendency will need help in confronting or discussing the trauma. However, an exposure that is too brief, such as in debriefing, may exacerbate, rather than ameliorate, distress.<sup>5</sup>

These are still hypotheses without supporting evidence. But since they bear directly on how an early psychological intervention after a trauma might proceed they are worthy of attention. There is little evidence to support current debriefing practices, and little is known about why debriefing might adversely affect recovery. There does, however, continue to be a great need for an early intervention that is demonstrably effective after a trauma.

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## Driving after repair of groin hernia

*It is usually safe after a week with repairs that do not put tissues under tension*

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**S**urgeons have traditionally advised patients recovering from groin hernia repairs not to drive for a month or two. This is based on the concern that postoperative pain could prolong reaction times and, to a lesser degree, that there is a risk of early recurrence as a result of the inertial forces that occur during a sudden impact or stop. However, preclusion from driving, particularly in the major cities around the globe, can have socioeconomic consequences.

Fortunately, by alleviating traditional concerns (and restrictions) about driving, the modern method of hernia repair is improving not only patients' physical wellbeing but their social and psychological recovery as well.

The pain that follows the repair of hernias in the groin is caused by mechanical and chemical stimulation of large, myelinated nerve fibres (A- $\alpha$  fibres) or small, unmyelinated nerve fibres (C fibres). Mechanical stimulation of somatic tissues, such as that which occurs when tension is created on the fibroconnective

tissue of the groin, causes pain both directly—through mechanical stimulation of A- $\alpha$  and C fibres—and indirectly—through the release of chemical substances that further stimulate the C fibres.<sup>1</sup> Such chemical substances include hydrogen, potassium, bradykinin, serotonin, histamine, acetylcholine, proteolytic enzymes, and prostaglandins.<sup>1-5</sup> In addition, the same chemical substances cause visceral pain by stimulating the C fibres that innervate the hernia sac (peritoneal sac) that is excised and ligated during the traditional repair.

The traditional method of hernia repair, which includes forceful approximation of the fibroconnective tissues of the groin, is associated with undue tension on the suture line, which leads to somatic pain through C and A- $\alpha$  nerve fibres. In addition, ligation of the hernia sac results in visceral pain, caused by mechanical stimulation and ischaemic changes in the peritoneum that lead to the release of chemical substances. Fortunately, modern hernia repairs avoid approximating tissues under tension by using a layer of synthetic

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